STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155572	B. WIN	G		05/25/2	011
NAME OF P	ROVIDER OR SUPPLIER	"	•		ADDRESS, CITY, STATE, ZIP CODE	•	
AUTUMN HILLS HEALTH AND REHAB CENTER			1	N 600 E COUNTY LINE RD			
AUTUMN	I HILLS HEALTH AI	ND REHAB CENTER		DEMO	ΓΤΕ, IN46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r the Investigation of	FO	000			
		0089789 & IN 00089888.	10	000			
	Complaints 11400	0009789 & IN 00089888.					
	Complaint INOO	089789 - Substantiated.					
	•	riciencies related to the					
		ited at F157 and F309.					
	anegations are en	ned at 1 137 and 1 307.					
	Complaint IN00	089888 - Substantiated.					
	•	iciencies related to the					
		ited at F281, F282, and					
	F329.	ited at 1 281, 1 282, and					
	1329.						
	Survey dates: Ma	ay 24 & May 25, 2011					
	2 42 7 6 9 444 6 5 1 2	,					
	Facility number:	000471					
	Provider number						
	AIM number: 10						
	Survey team:						
	Kathleen (Kitty)	Vargas, RN, TC					
	Janet Adams, RN						
	, , , , , , , , , , , , , , , , , , ,						
	Census bed type						
	SNF/NF: 67						
	Total: 67						
	Census payor typ	pe:					
	Medicare: 13	•					
	Medicaid: 42						
	Other: 12						
	Total: 67						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QO2411

Facility ID:

000471

TITLE

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155572	B. WIN	IG		05/25/2	011
NAME OF P	ROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
A 1 1 18.48		ID DELIAD OFNITED		1	N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH AN	ID REHAB CENTER		DEMO	ГТЕ, IN46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Sample: 8						
	These deficiencie	es reflect state findings					
	cited in accordan	ce with 410 IAC 16.2.					
		pleted 6/1/11 by Jennie Bartelt,					
	RN.						
F0157	A facility must imm	nediately inform the	ł				
SS=D	•	with the resident's physician;					
		y the resident's legal					
	•	an interested family member					
		ccident involving the					
		ults in injury and has the ing physician intervention; a					
		in the resident's physical,					
		social status (i.e., a					
	deterioration in he	•					
		s in either life threatening					
		al complications); a need to					
	_	nificantly (i.e., a need to					
		sting form of treatment due uences, or to commence a					
		nent); or a decision to					
		ge the resident from the					
	facility as specified	l in §483.12(a).					
	The feeilite	la a muananth coatt tt-					
	_	lso promptly notify the bown, the resident's legal					
		nterested family member					
	•	ange in room or roommate					
	assignment as spe	ecified in §483.15(e)(2); or					
	_	nt rights under Federal or					
		ations as specified in					
	paragraph (b)(1) o	of this section.					
	The facility must re	ecord and periodically					
		s and phone number of the					
	resident's legal rep	presentative or interested					
	family member.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPI	LETED
		155572	B. WIN			05/25/2	.011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	N 600 E COUNTY LINE RD		
	N HILLS HEALTH A	ND REHAB CENTER		1	ГТЕ, IN46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	F.0	TAG	·		DATE
		ation, record review and	FO)157	F157		06/24/2011
	· ·	cility failed to ensure the			I. Resident F: Orde	rs	
	1 ^ *	otified related to the need			were received for removal of		
		re surgical wound care for			staples on 5/25/11 and they		
	1 of 3 residents	reviewed for surgical			removed. Surgeon was not		
	wound care. (Re	esident #F) The facility			and stated that no follow up or care was needed. Surgion		
	also failed to ens	sure the physician was			assessed, edges were well	ai silt	
	notified related t	to the need for care of			approximated and there we	re no	
	cardiac pacemak	ters for 2 of 3 residents			signs of infection noted.		
	with cardiac pac	emakers in a sample of 8.			Resident B has been discha	arged	
	(Residents # B & #J) Findings include:				from this facility.	had	
					Resident J we have request pacemaker records and	leu	
					pacemaker settings from the	е	
					hospital. Physician notified		
	 1 On 5/24/11 at	10:10 a.m., during			need for pacemaker follow	Jp,	
		Resident #F was		pacemaker check will be scheduled. II. All residents admitted in			
		The Nurse Consultant					
					the past thirty days were rev		
					to ensure that any surgical		
	1	-			wounds follow up was		
	1 *	ion of the lower					
	extremity.						
	0.5/04/11	45 4 .			notified as indicated.	-	
		•			All residents in facility have	been	
					assessed to identify those		
	1				· ·		
	1 -	-					
	site was not cove	ered with a dressing or a					
	on 5/25/11 at 2:20 p.m., the resident was observed in the therapy room seated in a wheelchair. The surgical wound on the				have been scheduled as		
					indicated. Physicians notific	ed as	
					indicated.		
					III In-service for licen	hasi	
		nity was observed to have			monitoring of pacemaker fu		
		there was no dressing or			completed 6/9/11.		
	had recently bee after an amputat extremity. On 5/24/11 at 2: seated in a whee nurses' station. Tamputation of his site was not coverap. On 5/25/11 at 2: observed in the twheelchair. The left lower extrem	45 p.m. the resident was lchair in front of the The resident had an s left leg. The amputation ered with a dressing or a 20 p.m., the resident was therapy room seated in a surgical wound on the mity was observed to have			to ensure that any surgical wounds follow up was completed. Any wound can follow up that was needed heen completed. Physician notified as indicated. All residents in facility have assessed to identify those pacemakers. Medical recorbe reviewed to identify pres of pacemaker and pacemak settings. Pacemaker check have been scheduled as indicated. Physicians notificindicated. III. In-service for licen staff on Pacemaker policy a monitoring of pacemaker fu	e has s been with do to ence ser s ed as sed and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/25/2	ETED	
AUTUMN		ND REHAB CENTER	B. WIN	STREET A 10352 N DEMOT	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TE, IN46310	OGIZOIZ	
	SUMMARY S (EACH DEFICIEN REGULATORY OR Wrap on the surg Interview with L p.m. indicated th ordered for the re The record for R on 5/25/11 at 1:4 admitted to the fa resident had diag were not limited amputation, cong peripheral vascul hypertension. The hospital disc 5/9/11, indicated	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ical site. PN #1 on 5/2/11 at 12:00 ere was no treatment esident's amputation site. esident #F was reviewed 0 p.m. The resident was acility on 5/12/11. The moses that included, but to, left above the knee gestive heart failure, ar disease, and charge summary, dated the resident had an imputation of his left				on ow up risits, signee e that s re are ons ker r is	(X5) COMPLETION DATE
	Assessment dated resident had a left amputation. The staples intact and length. Review of the addated 5/12/11, in orders for care of There were no pl dressing, no remove the staples in	surgical wound had 29 I was 18 centimeters in mission physician orders, dicated there were no f the surgical wound. hysician orders for a loval date for the staples, eturn visit to the surgeon			Administration Record. Audit results will be reviewed QA monthly for 3 months the quarterly x2. V. Correction Date 6/24/2011		

000471

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		(X2) M A. BUII B. WIN	LDING	nstruction 00	(X3) DATE : COMPL 05/25/2	ETED	
	PROVIDER OR SUPPLIER	II S ND REHAB CENTER	p. wiiv	10352 N	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	prosthetic fitting						
	through 5/25/11 were no physicia removal or post- The nursing prog through 5/25/11 was no documen notify the attend surgeon of the no orders for the car. There was no do	gress notes dated 5/12/11 were reviewed. There tation of any attempts to ing physician or the eed for post-operative re of the surgical wound. cumentation that the					
		eed to obtain a date for aples.					
	5/25/11 at 3:15 p had staples in his after the surgery indicated the atte the surgeon show orders for the ren	ne Nurse Consultant on o.m. indicated the resident is amputation site, 29 days. The Nurse Consultant ending physician and/or all have been notified that moval of the staples and the care of the surgical ded.					
	reviewed on 5/25 resident was adn 7/2/08. The resident we included, but we	cord for Resident #B was 5/1 at 1:00 p.m. The nitted to the facility on lent had diagnoses that re not limited to, ssion, pacemaker and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		155572	B. WIN			05/25/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			N 600 E COUNTY LINE RD		
AUTUM	N HILLS HEALTH A	ND REHAB CENTER		1	TTE, IN46310		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	atrial fibrillation						
	The quarterly M	DS (Minimum Data Set)					
	1 1	pleted on 2/4/11,					
	indicated the resident had a cardiac pacemaker in place.						
	purcentumer in pro						
	Review of the fo	orm titled "Physician					
		Long-Term Care					
		as dated 7/1/08 indicated					
	the resident's primary diagnosis was cardiac pacemaker placement.						
	cardiac paceillas	ter placement.					
	The form titled '	'Care Plan Conference					
		dated 7/17/08, indicated					
	1	al was long-term care, it					
	1						
		e cardiologist was to be					
	notified for Post	Care.					
	Review of the m	nedical record indicated					
		ysician's order for					
	1	ry check. There was no					
		hat the function of the					
	resident's pacem	aker had been checked.					
	The policy titled	, "Care of Resident with a					
		iac Pacemaker" was					
	1 -	Nurse Consultant on					
	_	icy was revised on					
		cated the policy was					
	current. The poli	icy indicated:					
		periodic pacemaker					
	battery check. Sp	pecial equipment required					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 05/25/2	ETED	
	PROVIDER OR SUPPLIEF	ND REHAB CENTER		10352 N	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	to physician's of An alternate may (electrocardiogra via special phono battery life is app months.	nm) which is transmitted e equipment. Normal proximately 30-60					
	skilled nursing fareview of the dis	cated no instructions for					
	5/25/11 at 8:45 a no documentation pacemaker batter for the resident of facility from 7/2 also indicated the that the physicial for orders related	ne Nurse Consultant on a.m. indicated there was on that periodic ry checks were completed during her stay at the /08 through 2/11/11. She ere was no documentation in was notified of the need of the med acemaker as required by					
	of residents who	he facility provided a list had cardiac pacemakers. listed as having a cardiac					
	on 5/25/11 at 9:0	esident #J was reviewed 00 a.m. The resident was acility on 3/4/09. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		A. BUI	ILDING	NSTRUCTION 00	(X3) DATE (COMPL 05/25/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			N 600 E COUNTY LINE RD		
AUTUM	N HILLS HEALTH AI	ND REHAB CENTER		DEMOT	TE, IN46310		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU	†	gnoses that included, but		IAU			DATE
	were not limited	-					
		diovascular disease, and					
	1 *	ia with psychotic features.					
		1 3					
	The quarterly M	DS, completed on 5/4/11,					
	indicated the res	ident had a cardiac					
	pacemaker.						
	1	orders were reviewed.					
	1	hysician's order for					
	pacemaker batte	ry check.					
	Review of the ca	are plan initiated on					
		the resident has altered					
		tatus related to congestive					
		pertension, arrhythmia					
	1	ery disease. There was no					
	indication on the	e care plan of a cardiac					
	pacemaker or the	e need for periodic					
	pacemaker batte	ry checks.					
		ne Nurse Consultant on					
	1	o.m. indicated that she had					
		sident's daughter. The					
	_	ter stated the resident had or three years prior to					
	1 1	o the facility. She stated					
	_	ormation to the facility					
	_	ne pacemaker checks					
	1 -	She stated that she knew					
		performed a pacemaker					
	1 .	telephone at least one					
	time.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED	
	155572			B. WING 05/25/2011				
AUTUMN		ND REHAB CENTER		10352 N DEMOT	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
F0281 SS=D	Consultant on 5/2 indicated there we the physician was orders related to of the resident's particles. This federal tag is #IN00089789. 3.1-5(a)(3) The services proving facility must meet equality. Based on record facility failed to particularly standards of qualifollowing the five administration for sample of 8 who that had been dis Physician. (Resident Physician). (Resident Physician) (Resident Physician) included the United Physician and Phy	ded or arranged by the professional standards of review and interview, the provide professional ity related to not e rights of medication or 1 of 1 resident in the received a medication continued by the dent #D) (LPN #1)	FO	281	F281 I. Resident D had no adverse effects from the medication error made on 4/23/11. Medication error for had been previously complet prior to survey and physician family were notified. II. Completed review of medication and treatment red for the last 30 days to ensure changes in orders are clearly marked and that medications have been administered as ordered. Medication Error red have been completed and physicians notified as indicated.	ed and of cords e that // s	06/24/2011	

000471

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155572	B. WIN	IG		05/25/20	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TO THE OT 1	NO VIDER OR SOLI EIER			1	N 600 E COUNTY LINE RD		
AUTUMN	N HILLS HEALTH AN	ND REHAB CENTER		DEMOT	ΓΤΕ, IN46310		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	five rights were a	as follows:			III. Licensed nurses at	-	
	Right Patient				QMA's have been re-educate Rights of Medication	ea on	
	Right Drug				Administration, Policy on		
	Right Dose				Medication Errors/Reports,		
	Right Time				Medication Discontinuation a	and	
	Right Route				Disposition, Verification of		
	•	e administration of the			physician orders if the order the MAR/TAR are unclear, a		
		e to match the drug label			Notification of Physician and		
		on the Medication			DON.		
	Administration R						
	The record for Resident #D was reviewed				IV. Telephone orders a	nd	
					Medication and Treatment Administration Records will I	_	
	on 5/24/11 at 12:15 p.m. The resident was admitted to the facility on 3/1/11.				reviewed a minimum of three		
					times per week to ensure	·	
					accuracy of records. DON of	r	
	•	rs obtained on 3/1/11			designee will do at least 5		
		ident was to receive			medication pass observation	is per	
	`	nxiety medication) 0.5			week on varied shifts. The results of these audits and		
		a day. A Physician's			observations will be reviewe	d	
	order was writter				monthly in QA for 3 months		
	discontinue the A	Ativan.			quarterly x2.		
		11.3.6.15			V. Correction Date:		
	Review of the 4/				6/24/2011		
		Record indicated the					
		the Ativan twice a day					
		/20/11. There was					
	_	edication Administration					
		ne for signing out the					
	medication that t	he medication was					
	discontinued on	4/21/11. The line was					
	highlighted yello	w also at the time of the					
	review. The me	dication was signed out					
	as given on 4/23/						
	A Medication E	ror Report" dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155572	B. WIN			05/25/2011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
A LITLINAN		ID DELIAD CENTED		1	N 600 E COUNTY LINE RD		
		ND REHAB CENTER			TTE, IN46310		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	ATE
		ewed. The report					
		•					
	indicated Resident #D received a dose of Ativan at 8:00 a.m. on 4/23/11 after the						
		discontinued. The report					
		or was discovered after					
	the medication w						
		d let the Nurse know the					
	Ativan was to ha	ve been discontinued.					
	The report also in	ndicated the "Medication					
	Book" was circle	ed as the source of					
	information regar	rding the medication					
	given. "Chart" w	vas not circled. The					
	"Type of Error"	was marked as "Wrong					
	Medication"						
	When interviewe	ed on 5/24/11 at 3:10					
	p.m., LPN #1 ind						
		ose of Ativan to Resident					
		8:00 a.m. The LPN					
		van previously had been					
		en at 8:00 a.m. and 8:00					
	_	dicated there was writing					
		n Administration record					
	ı	to be discontinued but at					
		that writing was pertinent					
	-	o.m. dose and not the					
		PN indicated the Ativan					
	_	hlighted yellow as					
		dications usually are.					
		d she did not look at the					
	I -	rs at that time. LPN#1					
		coming evening shift					
		2:00 p.m. and the					
	oncoming Nurse	indicated both doses of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		LDING	00	COMPL 05/25/2	ETED
	PROVIDER OR SUPPLIER	I ND REHAB CENTER	p. wiii	10352 N	DDRESS, CITY, STATE, ZIP CODE I 600 E COUNTY LINE RD TE, IN46310	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	not fill out a Mec that time. The La occurred on a we not notify the Dir she returned to w. When interviewed p.m., the Directonursing staff wer Medication Error made. The Directonursing staff wer Medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician of 4/21/11 to discontinuous medication error #D received a doafter Physician error #D received a doafter Physicia	PN #1 indicated she did dication Error Report at PN indicated this sekend shift and she did rector of Nursing until work on Monday. Ed on 5/24/11 at 3:50 or of Nursing indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMPI 05/25/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD		
AUTUMN	N HILLS HEALTH A	ND REHAB CENTER		DEMOT	ΓΤΕ, IN46310		
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F0282 SS=D	facility must be proin accordance with plan of care. Based on record facility failed to related to the admedication after medication to be resident reviewed medications being sample of 8, who in error. (Resident #D) (LPN #1) Findings include The record for R on 5/24/11 at 12: was admitted to Physician's order indicated the resident was writted discontinue the Administration Fresident received 4/1/11 through 4	the physician ordered the discontinued for 1 of 1 d related to discontinued ag administered in a preceived a medication : : : : : : : : : : : : :	F0	2282	F282 I. Resident D had not adverse effects from the medication error made on 4/23/11. Medication error for had been previously comple prior to survey and physicial family were notified. II. Completed review medication and treatment refor the last 30 days to ensur changes in orders are clear marked and that medication have been administered as ordered. Medication Error reformative been completed and physicians notified as indication. III. Licensed nurses a QMA's have been re-education and Treatment physician orders if the order the MAR/TAR are unclear, a Notification of Physician and DON. IV. Telephone orders and Medication Records will reviewed a minimum of three	orm eted n and of ecords re that ly as eports ated. and on and d and be	06/24/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPI		
AND PLAN	OF CORRECTION	155572	A. BUI	LDING	00	05/25/2	
		100072	B. WIN		PRESIDENCE CONTROL CON	03/23/2	.011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD		
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	Record on the lin	e for signing out the			times per week to ensure		
	medication that t	he medication was			accuracy of records. DON o	or	
	discontinued on 4	4/21/11. The line was			designee will do at least 5 medication pass observation	ns ner	
	highlighted yello	w also at the time of the			week on varied shifts. The	io poi	
	review. The me	dication was signed out			results of these audits and		
	as given on 4/23/	11 at 8:00 a.m.			observations will be reviewe		
					monthly in QA for 3 months quarterly x2.	inen	
	A Medication En	ror Report" dated 4/25/11			quality na.		
	was reviewed. T	he report indicated			V. Correction Date:		
	Resident #D rece	eived a dose of Ativan at			6/24/2011		
	8:00 a.m. on 4/23	3/11 after the Ativan had					
	been discontinue	d. The report indicated					
	the error was disc	covered after the					
	medication was g	given and the resident's					
	husband let the N	Jurse know the Ativan					
	was to have been	discontinued. The report					
	also indicated the	e "Medication Book" was					
	circled as the sou	arce of information					
		dication given. "Chart"					
	was not circled.	The "Type of Error" was					
	marked as "Wror	ng Medication"					
		ed on 5/24/11 at 3:10					
	p.m., LPN #1 inc						
		ose of Ativan to Resident					
		8:00 a.m. The LPN					
		van had previously been					
		at 8:00 a.m. and 8:00					
	1 ^	ndicated there was					
	_	edication Administration					
		it was to be discontinued					
		e felt that writing was					
	pertinent only to	the 8:00 p.m. dose and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155572 05/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10352 N 600 E COUNTY LINE RD AUTUMN HILLS HEALTH AND REHAB CENTER DEMOTTE, IN46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE not the 8:00 a.m. When interviewed on 5/24/11 at 3:50 p.m., the Director of Nursing indicated a medication error was made when Resident #D received a dose of Ativan on 4/23/11 after Physician orders were written on 4/21/11 to discontinue the medication. This Federal tag relates to Complaint IN00089888. 3.1-35(g)(2)F0309 Each resident must receive and the facility SS=D must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F309 F0309 06/24/2011 Based on observation, record review and Resident F: Orders interview, the facility failed to ensure were received for removal of necessary care and services were provided staples on 5/25/11 and they were for post-operative care of a surgical removed. Surgeon was notified and stated that no follow up visit wound for 1 of 3 residents reviewed for or care was needed. Surgical site surgical wound care. (Resident #F) The assessed, edges were well facility also failed to ensure the approximated and there were no monitoring of cardiac pacemaker function signs of infection noted. Resident B has been discharged was completed for 2 of 3 records from the facility. reviewed for pacemaker monitoring in a Resident J we have requested sample of 8. (Residents # B & #J) pacemaker records and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QO2411

Facility ID:

000471

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETI	ED
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			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				N 600 E COUNTY LINE RD		
AUTUM	N HILLS HEALTH AN	ND REHAB CENTER		1	TE, IN46310		
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	Findings include 1. On 5/24/11 at orientation tour, observed in bed. indicated, at that had recently beer after an amputation extremity. On 5/24/11 at 2:4 seated in a wheel nurses' station. Tamputation of hi	: 10:10 a.m., during Resident #F was The Nurse Consultant time, that the resident n admitted to the facility			pacemaker settings from the hospital. Physician notified need for pacemaker follow up acemaker check will be scheduled. II. All residents admit the past thirty days were revito ensure that any surgical wounds follow up was completed. Any wound care follow up that was needed his been completed. Physicians notified as indicated. All residents in facility have assessed to identify those was pacemakers. Medical record be reviewed to identify pressor of pacemaker and pacemak settings. Pacemaker checks have been scheduled as indicated. Physicians notified indicated.	ed in iewed as s been with d to ence er s	
	observed in the t wheelchair. The left lower extrem staples in place, wrap on the surg Interview with L p.m. indicated th ordered for the record for R on 5/25/11 at 1:4 admitted to the firesident had diag	20 p.m., the resident was herapy room seated in a surgical wound on the nity was observed to have there was no dressing or ical site. PN #1 on 5/2/11 at 12:00 ere was no treatment esident's amputation site. esident #F was reviewed to p.m. The resident was accility on 5/12/11. The gnoses that included, but to, left above the knee			III. In-service for licen staff on Pacemaker Policy a monitoring of pacemaker fur completed 6/9/11. In-service for licensed staff of surgical wound care and follocare (treatments, follow up of staple/suture removal) was completed 6/9/11 IV. Admissions and Re-admission orders will be reviewed by the DON or deswithin 24-72 hours to ensure all pertinent treatment order related to surgical wound call and follow up appointments present and scheduled. All Admissions and Re-admissions and Re-admissions and Re-admissions.	ignee that sere	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155572 05/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10352 N 600 E COUNTY LINE RD AUTUMN HILLS HEALTH AND REHAB CENTER DEMOTTE, IN46310 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE amputation, congestive heart failure, will be reviewed for pacemaker placement, and if pacemaker is peripheral vascular disease, and present will ensure hypertension. documentation of settings, and frequency of pacemaker checks are recorded on the physician The hospital discharge summary, dated order sheet. Frequency of 5/9/11, indicated the resident had an pacemaker checks will also be above the knee amputation of his left recorded on the Treatment lower extremity on 4/26/11. Administration Record. Audit results will be reviewed in QA monthly for 3 months then The Admission/Readmission Nursing quarterly x2. Assessment dated 5/12/11 indicated the resident had a left above the knee Correction Date V. amputation. The surgical wound had 29 6/24/2011 staples intact and was 18 centimeters in length. Review of the admission physician orders, dated 5/12/11, indicated there were no orders for care of the surgical wound. There were no physician orders for a dressing, no removal date for the staples, no orders for a return visit to the surgeon and no orders for stump care for prosthetic fitting. The physician's orders dated 5/12/11 through 5/25/11 were reviewed. There were no physician orders related to staple removal or post-operative care. The nursing progress notes dated 5/12/11 through 5/25/11 were reviewed. There was no documentation of any attempts to contact the attending physician or the

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		ND REHAB CENTER		L	TE, IN46310		
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	surgeon to obtain for the care of the was no document physician or the obtain a date for Interview with the 5/25/11 at 3:15 phad staples in his after the surgery were no orders for staples. She indicated orders for staples and for puricial wound. 2. The closed recreviewed on 5/25 resident was adm 7/2/08. The resident was adm 7/2/08. The resident was adm 3/2/08. The resident was adm 3/2/08	n post-operative orders e surgical wound. There tation that the attending surgeon was contacted to removal of the staples. ne Nurse Consultant on o.m. indicated the resident is amputation site, 29 days . She also indicated there for the removal of the cated staff should have for the removal of the ost-operative care of the cord for Resident #B was 5/1 at 1:00 p.m. The nitted to the facility on dent had diagnoses that re not limited to, ssion, pacemaker and . DS (Minimum Data Set) pleted on 2/4/11, ident had a cardiac			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	
		as dated 7/1/08 indicated mary diagnosis was er placement.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155572	B. WIN			05/25/2	011
			P. 1121		ADDRESS, CITY, STATE, ZIP CODE		
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AUTUM	N HILLS HEALTH AN	ND REHAB CENTER		1	TTE, IN46310		
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	Summary " and of the resident's goal also indicated the notified for Post Review of the man there was no phy pacemaker batter documentation the resident's pacema. The policy titled Permanent Cardia provided by the 15/25/11. The policy of the policy titled Permanent Cardia provided by the 15/25/11. The policy of the policy	edical record indicated visician's order for ry check. There was no hat the function of the aker had been checked. "Care of Resident with a fac Pacemaker" was Nurse Consultant on icy was revised on cated the policy was cy indicated: periodic pacemaker pecial equipment required by be done via telephone fice or pacemaker clinic. The bean ECG am) which is transmitted by the equipment. Normal proximately 30-60					
	skilled nursing fa	acility on 2/11/11, and					
	review of the dis	-					
		cated no instructions for					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155572	B. WIN	G		05/25/20	011
	PROVIDER OR SUPPLIER	ND REHAB CENTER	'	10352 N	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD TTE, IN46310		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
	cardiac pacemak	er checks.	Ī				
	Interview with the 5/25/11 at 8:45 a no documentation pacemaker batter for the resident defacility from 7/2/2 also indicated the orders related to of the pacemaker policy. 3. On 5/24/11, the of residents who Resident #J was pacemaker. The record for Resident who admitted to the faresident had diag were not limited dysfunction, card vascular demention. The quarterly MI indicated the resident had care pacemaker.	ne Nurse Consultant on .m. indicated there was in that periodic by checks were completed during her stay at the 208 through 2/11/11. She were were no physician monitoring the function of as required by facility as required by facility in the facility provided a list had cardiac pacemakers. Instead as having a cardiac wesident #J was reviewed 0 a.m. The resident was acility on 3/4/09. The moses that included, but to, sinus node thousacular disease, and a with psychotic features. DS, completed on 5/4/11, ident had a cardiac orders were reviewed.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/25/2	ETED	
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	2/8/11 indicated cardiovascular sheart failure, hyp and coronary art indication on the pacemaker or the pacemaker batte. Interview with the 5/25/11 at 2:05 p spoken to the resident's daught the pacemaker for t	the resident has altered tatus related to congestive pertension, arrhythmia ery disease. There was no exare plan of a cardiac eneed for periodic ry checks. The Nurse Consultant on the indicated that she had sident's daughter. The ter stated the resident had for three years prior to to the facility. She stated formation to the facility the pacemaker checks the stated that she knew performed a pacemaker telephone at least one with the Nurse 25/11 at 2:05 p.m. Evere no physician's orders foring the function of the taker. She indicated the facemaker had not been trelates to Complaint					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			(X2) MULTIPLE CC A. BUILDING B. WING	00	(x3) date survey COMPLETED 05/25/2011
	PROVIDER OR SUPPLIER	ND REHAB CENTER	103521	ADDRESS, CITY, STATE, ZIP CODE N 600 E COUNTY LINE RD ITE, IN46310	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug we (including duplicate duration; or without without adequate in the presence of account indicate the dose sed discontinued; or an reasons above. Based on a compromer resident, the facility residents who have drugs are not give antipsychotic drug treat a specific coordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discounterview, the factor resident's drug resident drug resi	ug regimen must be free drugs. An unnecessary when used in excessive dose therapy); or for excessive at adequate monitoring; or indications for its use; or indiverse consequences which should be reduced or my combinations of the rehensive assessment of a y must ensure that the not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and antipsychotic drugs receive ctions, and behavioral is clinically contraindicated, continue these drugs. The action, record review, and ceility failed to ensure the regime was free of greated to the lack of the use of and on going the continued use of an cation for 1 of 3 residents use of anitanxiety in the sample of 8.	F0329	F329 I. Ativan for Resident was discontinued on 4/21/20 II. Audit of all psychot medications completed to en appropriate diagnosis or indication for use and appropriate monitoring is present for eac medication. III. All admission/re-admission	11 ropic sure priate

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/25/2	ETED	
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	Findings include: On 5/24/11 at 11:35 a.m., Resident #D was observed in bed. The resident was awake and calm. On 5/24/11 at 12:55 p.m., the resident was resident was observed sitting in a wheel chair in the Dining Room. The resident was quiet at this time. The resident was not displaying any behaviors at the above times. On 5/25/11 at 8:30 a.m., the resident was observed in a wheelchair. The resident was being fed was awake and quiet. The resident was being wheeled into her room by a staff member. On 5/25/11 at 9:45 a.m., the resident was observed asleep in her bed. The resident was not displaying any behaviors at the above times.			IAG	medication orders will be reviewed upon admission to ensure appropriate diagnosi and/or indication for use and monitoring are present. Soo Service and pharmacist will review psychotropic medical monthly to ensure diagnosis and/or indication for use and monitoring are appropriate a ongoing. They will make recommendations for gradual dose reductions as indicated In-service for licensed staff completed for documentation behaviors, behavior manage plans and obtaining approprice diagnosis or indication for earmedication, and monitoring side effects and effectiveness IV. Audits will be review monthly in QA for three monthen quarterly x two. V. Correction Date 6/24/2011	s I iial iions I ind I i. in for ement iiate iiate iich for ess. wed	DAIL
	on 5/24/11 at 12 admitted to the f hospital. The res included, but we vascular acciden pressure, and and diagnosis of anx record at this time and Physician while hospitalized indi	esident #D was reviewed at 15 p.m. The resident was facility on 3/1/11 from the ident's diagnoses are not limited to, cerebral at (stroke), high blood emia. There was no itely in the the resident's ne. Review of a History ort completed by the the resident was cated the resident was asspital on 2/24/11.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572			LDING	NSTRUCTION 00	(X3) DATE (COMPL 05/25/2	ETED	
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		agnosis of anxiety noted and Physical report. The					
	1	medications listed in the					
	History and Phy	sical did not include any					
	antianxiety med	ications.					
	The facility mali	ov titlad					
	The facility police "Psychopharmac	cy med cological Medications"					
		om the Nurse Consultant					
	on 5/25/11 at 1:1	15 p.m. and identified as					
	the current polic	y. There was no date on					
		policy was reviewed at					
	_	olicy indicated the facility					
		each resident regarding					
		opharmacological ne policy also indicated					
		acy of the medications					
		ored through the care					
		s and include supporting					
		e medication and					
	exhibited behavi	ors which warranted the					
	use of the medic	ation.					
	Review of the 3	/1/11 Physician orders					
		vas an order for the					
		ve Ativan (an antianxiety					
		milligrams twice a day.					
		ritten on 4/13/11 to					
	_	s the Ativan was to be					
	"	a.m. and 4:00 p.m. to					
		00 p.m. An order was					
		11 to discontinue the					
	Ativan.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572			(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 05/25/2	ETED
	PROVIDER OR SUPPLIER	II	<u></u>	STREET A 10352 N	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310		
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	The 3/8/11 Mini admission assess resident had not verbal behaviors MDS assessmen was receiving an and did not have Anxiety Disorded. Physician Progret 3/1/11 and 4/11/diagnoses of anxietist behavior. The Nurses' Not 4/19/11 indicated documentation of an signs of anxietist behaviors. The reviewed. Therefore place related to the any anxious or a social Service P though 4/21/11 to documentation receiving Ativantime. There was resident displaying behaviors or diagrams.	ess Notes completed on 11 indicated there was no ciety or aggressive rs. es from 3/1/11 thru d there was no of the resident displaying ety or aggressive resident's care plans were exercise were no care plans in the resident displaying ggressive behaviors.		TAG	DEFICIENCY)		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155572		A. BUIL	LDING	NSTRUCTION 00	(X3) DATE: COMPL 05/25/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A 10352 N	DDRESS, CITY, STATE, ZIP CODE 1 600 E COUNTY LINE RD TE, IN46310	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	support the conti 0.5 milligrams tv	nued use of the Ativan vice a day.					
	a.m., the Social Resident #D was she was admitted discontinued on a voiced concerns sleepy and that w. When interviewed p.m., the Directoresident had order when she was ad 3/2011. The Directoresident had order when interviewed p.m., the Directoresident had been 3/1/11 through 4/2. Nursing indicated diagnosis for the Ativan. The Directoresident had been 3/1/11 through 4/2. Nursing indicated diagnosis for the Ativan. The Directoresident had been 3/1/11 through 4/2. Nursing indicated diagnosis for the Ativan. The Directoresident had been 3/1/11 through 4/2. Nursing indicated there we behaviors or more continued need of the same admits a supplied that the same admit	Worker indicated receiving Ativan when and the medication was 4/21/11 after the family with the resident being was affecting her therapy. Indoor 5/25/11 at 12:30 or of Nursing indicated the ears to receive Ativan mitted to the facility in ector indicated there was the use of the antianxiety and on 5/25/11 at 2:45 or of Nursing indicated the ears to receive Ativan mitted to the facility in ector indicated there was the use of the antianxiety and on 5/25/11 at 2:45 or of Nursing indicated the eneceiving Ativan from 1/21/11. The Director of the ector of Nursing was no documentation of antioring to indicate the of the medication.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD		
AUTUMN	I HILLS HEALTH AN	ND REHAB CENTER	DEMO ⁻	TTE, IN46310	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
	3.1-48(a)(4)				